VA Prescription Form

Ohtuvayre® (ensifentrine) Inhalation Suspension 3 mg/2.5 mL

1. Forward this completed form to the VA Pharmacy
2. The VA Pharmacy will fax completed form to Verona Pathway Plus® at **833-392-8999**
3. CVS Specialty Pharmacy will be the dispensing pharmacy. Phone: **800-238-7828** UEID: **MMKYFJ5QGKM7**

Section 1 - Patient Information (required)

First Name: _____ Last Name: _____ Last Four SSN: _____

Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ ZIP: _____

Preferred Phone: _____ Secondary Phone: _____

Alternate Contact: _____ Alternate Contact Phone: _____

ICD-10-CM diagnosis code(s): _____

☐ Check here for delivery directly to patient's shipping address listed above. If information is incomplete, the prescription will be shipped to the VA Pharmacy listed below.

Section 2 - VA Pharmacy Information (required)

VA Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Clinical Contact: _____ Phone: _____

Fax: _____ Email: _____

Secondary Clinical Contact: _____ Phone: _____

Fax: _____ Email: _____

Payment Method: ☐ Credit card (call pharmacy contact) ☐ E-Invoice Tungsten Network ☐ Purchase Order #: _____

Primary Purchasing Contact: _____ Phone: _____

Fax: _____ Email: _____

Secondary Purchasing Contact: _____ Phone: _____

Fax: _____ Email: _____

Section 3 - Prescriber Information (required)

Prescriber Name: _____ NPI: _____

Practice Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

Office Contact: _____ Office Email: _____

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Ohtuvayre® (ensifentrine) Inhalation Suspension 3 mg/2.5 mL

Section 4 - Prescription (required)

Prescription for OHTUVAYRE

Rx: OHTUVAYRE (ensifentrine) inhalation suspension: 3 mg ensifentrine per 2.5 mL aqueous suspension in unit-dose ampule. Oral inhalation use only.

Directions:
- ☐ 3 mg (one unit-dose ampule) twice daily, once in the morning and once in the evening, administered by oral inhalation using a standard jet nebulizer with a mouthpiece.
- ☐ Other: _____

Quantity: ☐ 60 ampules (per box), 30-day supply _____ refills ☐ Other: _____ ampules; 30-day supply _____ refills

Standard Jet Nebulizer Prescription *Refills are good for 12 months unless otherwise noted* **Refill:** _____

☐ Standard Jet Nebulizer and Administration Set[1]
- E0570 - Compressor
- A7005 - Administration Set (one every 6 months)

☐ Administration Set ONLY[1]
- A7005 - Administration Set (one every 6 months)

The medication cost does not include the nebulizer and administration set. Those are provided at an additional charge.

Section 5 - Prescription Certification and Signature (required)

HEALTHCARE PROVIDER ATTESTATION

I represent and warrant that I or others in my practice ("my Practice") have obtained written authorization from the patient listed above (the "Patient") that complies with the HIPAA Privacy Rule. I represent and warrant that I am authorized under the laws of my state of license to prescribe OHTUVAYRE, that I have determined that OHTUVAYRE is medically appropriate for the Patient, and that I will supervise the Patient's treatment.

I consent to receive communications related to the Programs by telephone, email, and/or fax.

By signing, I certify that I have read and agree to the above Healthcare Provider Attestation and that the information provided is complete and accurate to the best of my knowledge.

I authorize Verona Pathway Plus to act on my behalf to transmit the prescription to a contracted network Specialty Pharmacy.

Prescriber Signature (Dispense as Written)	Prescriber Signature (Substitution Allowed)	Date (Required)

Prescriber signature required to validate prescriptions. The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription Form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber. Prescriber attests that this is prescriber's legal signature (NO STAMPS).

Healthcare Provider Name (Please Print): _____

Healthcare Provider Designation: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other: _____

To report a suspected adverse event or product quality complaint involving a specific Merck product, please contact the Merck National Service Center at 800-444-2080.

MERCK Verona Pathway Plus®

Reference: 1. Local coverage determination - nebulizers. Medicare Coverage Database (MCD). Centers for Medicare & Medicaid Services. Updated February 12, 2026. Accessed April 8, 2026. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33370

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